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Abstract

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Keywords

illnesses, identity, mental, exploring, serious, people, process, recovery, within

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

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ARTICLE

Exploring Identity within the Recovery Process of People with Serious Mental Illnesses



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Objective: To examine self-identity within the recovery processes of people with serious mental illnesses using a repertory grid methodology. **Method:** Cross-sectional study involving 40 mental health service consumers. Participants rated different “self” and “other” elements on the repertory grid against constructs related to recovery, as well as other recovery focused measures. **Results:** Perceptions of one’s “ideal self” represented more advanced recovery in contrast to perceptions of “a person mentally unwell.” Current perceptions of self were most similar to perceptions of “usual self” and least similar to “a person who is mentally unwell.” Increased identification with one’s “ideal self” reflected increased hopefulness in terms of recovery. **Conclusions:** The recovery repertory grid shows promise in clinical practice, in terms of exploring identity as a key variable within mental health recovery processes. Distance measures of similarity between various self-elements, including perceptions of others, maps logically against the recovery process of hope.

Keywords: identity, measurement, recovery, serious mental illnesses

Longitudinal studies have found that over two thirds of people with serious mental illnesses experience full or partial recovery (Corrigan & Ralph, 2005). Drawing consistent themes across first and third person accounts, a “psychological model of recovery” was developed (Andresen, Oades, & Caputi, 2003) defining recovery as “the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination” (p. 588), and identified a “five-stage,” four component process model of recovery. The four key component processes are: (i) finding hope, (ii) redefining identity, (iii) finding meaning in life, and (iv) taking respon-

sibility for recovery. The five stages are: (i) Moratorium, involving uncertainty, despair, identity confusion and self-protective withdrawal, (ii) Awareness, the realization that all is not lost and recovery is possible, (iii) Preparation, the person learns about the mental illness and develops an understanding of his/her strengths and limitations, (iv) Rebuilding, setting goals, managing the illness and taking control of own life, and (v) Growth, regarded as the outcome of recovery, where the individual is resilient against setbacks, knows how to stay well and retains a positive outlook.

Marin and colleagues (2005) explored the experiences of the person in recovery and found that “some of the participants talk about becoming *different* people as a result of their illness, others talk about becoming *better* people” (p. 239). Being a “different” person implies the notion of redefining identity, where becoming a “better” person implies a concept of growth in identity. Andresen et al. (2003) incorporated both concepts of identity change into their model. The idea of self-redefinition is expressed in terms of “seeing themselves as other than a sick person.” Expanding identity is articulated as “learning about one’s self” and “building on strengths.”

Psychodynamic (Erikson, 1968), humanistic (Kelly, 1955; Maslow, 1970), existential (May, 1958) and social psychological (e.g. self-discrepancy theory; Higgins, 1987) theories share two broad themes which are relevant to the concept of identity. The first is that of “self and not self,” involving one’s image of one’s self, who we perceive ourselves “to be” or “not to be.” This theme reflects the notion of “possible selves” that incorporates the past accounts of the self with images of future selves, including the ideal self, the self we could become, and are perhaps afraid of becoming (Markus & Nurius, 1986). The second theme, that of “self and others,” refers to our interactions with others and the environment (Viney, 1987). It includes social communications, as well as the decision to accept or reject social standards (Erikson, 1968).

Therefore identity can be seen as a self-construction process where one’s sense of self is continually created, challenged and recreated over a lifetime (Cox & Lyddon, 1997). Thus, identity is not fixed but rather a configuration of potentialities or possible selves (Markus & Nurius, 1986), a re-

flection of past, present and futures selves (self-constructs) influenced by social interactions.

Although identity is a key recovery process, neither Andresen et al. (2006) “Stages of Recovery Instrument,” nor other quantitative measures of recovery (e.g., Recovery Assessment Scale—Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) capture its complexity.

Personal Construct Theory’s (Kelly, 1955; see Winter, 1992a, for a summary of personal construct theory) fundamental postulate states that although objective reality exists, people do not experience this reality directly but interpret or construe their experiences in the world. To evaluate how people construe significant others or experiences in their lives Kelly developed the Role Construct Repertory Test (repertory grids) (Bell, 1988).

Repertory grids have been used to provide an empirical basis in which to investigate identity development and change (e.g., Madill & Latchford, 2005). A repertory grid can be defined “as a set of representations of the relationship between the set of things a person construes (the elements) and the set of ways that person construes them (the constructs)” (Bell, 1988, p. 102). Elements can be the names of real or imagined people and qualities (e.g. “my ideal self”). Constructs are bipolar dimensions used to think about and evaluate these elements (e.g. “healthy-unhealthy”) (Walker & Winter, 2007). Repertory grids can be either be “fixed” where the elements and/or constructs are supplied or “elicited” where the elements and/or constructs are obtained from the person (Bell, 2003).

The idea of “possible selves” is well captured by the repertory grid methodology by drawing comparisons between one’s current view of self and

past, future and ideal selves in terms of different constructs. Repertory grid data reflect the relationship between the elements and constructs, where the elements can be rated or ranked in terms of their constructs (Bell, 1988; Walker & Winter, 2007). Similarity or distance measures between the elements can then be used to identify changes in identity. It has been suggested that goals are more likely to be achieved when the distance between self now and ideal self is smaller (Jones & Hartmann, 1988). Therefore, when a person perceives themselves now as more similar to their ideal identity, the more likely they are to achieve their recovery goals. For example, studies examining distance measures between the “current self” and “ideal self” (Fexias, Erazo-Cacedo, Lewis Harter, & Bach, 2008) found that participants diagnosed with depressive disorder had current self-ideal self distances which were greater than when compared to non-clinical populations. The distance between self now and the ideal self could be seen as a measure of self-discrepancy (Higgins, 1987), where the greater the distance between the self now and the ideal self indicates a greater discrepancy between the actual/ideal self. Greater self-discrepancy is associated with greater psychological distress (i.e. a symptom measure of mental illness) (Higgins, 1987). However, contemporary views of recovery suggests that people may still progress their recovery, continue to pursue life goals, gain hope and psychological well-being (i.e. high well-being), despite the potential persistence of illness symptoms (Corrigan & Ralph, 2005; Keyes & Haidt, 2003). It might therefore be expected that self-discrepancy will also be associated with measures of well-being such as hopefulness.

Two studies used fixed format repertory grid with people who have experi-

enced a psychotic episode (Bell & McGorry, 1992) or their first psychotic episode (Harrigan, 1999). Distance measures between the elements were used in these studies to identify changes in identity over a twelve month period. However, repertory grids have not been used to investigate identity (via elements) in relation to the recovery process (via constructs) of people with chronic mental illness.

The current study investigates the process of identity in relation to the recovery of people with chronic mental illness, using a fixed format repertory grid. A cross-sectional investigation examines potential differences in identity data obtained from the repertory grid, along with other measures of hopefulness, meaning and self-responsibility in relation to recovery. Specifically, this study examines the degree of perceived similarity/difference between each of the repertory grid elements (self/other representations) in terms of recovery constructs (e.g. hopefulness). Of particular interest is the similarity between perceptions of current self and possible selves (e.g. ideal self) as well as perceptions of others. It is also expected that the recovery constructs used in the repertory grid will be positively correlated with other measures of recovery.

Method

Participants

Forty mental health service patients aged 18 or over participating in the Australian Integrated Mental Health Initiative High Support Stream project were recruited with consent for this study. The measures were collected from four community based mental health agencies offering a range of supported accommodation and psychosocial rehabilitation facilities in metropolitan, rural and regional

Australia (Crowe, Deane, Oades, Caputi, & Morland, 2006).

Participants had a diagnosis of a psychotic disorder of at least 6 months duration and had high support needs (as determined by > 5 total needs on the Camberwell Assessment of Needs (Phelan, Slade, & Thornicroft, 1995), without significant brain injury.

Measures

The Dispositional Hope Scale

This 12-item scale comprises four “agency” items (measures goal-directed determination), four “pathway” items (measures successful goal-directed planning) and four filler items which were not used in this study (Snyder et al., 1991). It generates a single score, where higher scores indicate greater dispositional hopefulness, and subscale scores for agency and pathway. Acceptable internal consistency (alpha range 0.74 to 0.84) and test-retest reliability ($r = 0.73$, $p < 0.01$) and good concurrent validity with the psychosocial variables such as optimism, problem solving and self-esteem have been reported (Snyder et al., 1991).

Self-Identified Stage of Recovery (SISR)

The SISR (Andresen, Caputi, & Oades, 2006) is a measure based on the stage model of recovery. It is comprised of five statements, where each statement represents a different stage of recovery, moratorium, awareness, preparation, rebuilding, and growth. The participant selects a single statement which best represents his or her present experience of recovery. This instrument correlates with the client-rated Recovery Assessment Scale ($r = 0.45$, $p < 0.05$) (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995), and client rated distress (Kessler-10) ($r = -0.32$, $p < 0.05$) (Kessler et al., 2002).

Recovery Assessment Scale—short (RAS-short)

The 24-item RAS-short (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004) is derived from a factor analysis of the original 41-item scale (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995). Participants rate the degree to which the 24 items describe their current experiences on a five point agreement scale (0 = strongly disagree; 4 = strongly agree). The RAS-short item-total correlations ranged from 0.39 to 0.83, indicating that all items are discriminating well and have good convergent validity with other recovery oriented scales such as the Stages of Recovery Measure (McNaught, Caputi, Oades, & Deane, 2007).

The SpREUK 1.1 Subscale – Positive Interpretation of Disease

The SpREUK (Bussing, Ostermann, & Matthiessen, 2005) subscale “positive interpretation of disease” is comprised of six items which are client rated on a five point agreement scale (0 = does not apply to me; 4 = applies very much). The internal reliability of the subscale was good with a Cronbach’s alpha of 0.80 (Bussing, Ostermann, & Matthiessen, 2005).

Personal Health Management Questionnaire (PHMQ) Subscale – Active involvement

The PHMQ was adapted from the Stages of Change Questionnaire (SOCQ) (McConaughy, Prochaska, & Velicer, 1983) for the purposes of assessing the “readiness to change” in people with chronic mental illness. The subscale “Active Involvement,” is comprised of four items which are client rated on a five point agreement scale (0 = strongly disagree to 4 = strongly agree). The subscale has good concurrent validity with SOCQ ($r = .80$, $p < .01$, for action subscale) and with Hope

($r = .43, p < .05$). The PHMQ has good reliability with a Cronbach's alpha of 0.77.

Recovery Repertory Grid

A fixed format repertory grid was developed for this study to measure changes in identity during recovery. The format of the repertory grid was based on the core recovery themes (Andresen, Oades, & Caputi, 2003; 2006), theories of identity (Boyatzis & Akrivou, 2006; Cox & Lyddon, 1997; Erikson, 1968; Kelly, 1955; Markus & Nurius, 1986), as well as the work of Bell and McGorry (1992) and Harrigan (1999). The repertory grid was further refined (see Appendix A) based on feedback received from participating people in recovery and service providers. Each element appears on a separate page with each of the constructs being rated on scale of 1 to 5. A rating of 1 indicates that they perceive that element as more like the left hand pole of the construct and a rating of 5 as more like the right hand pole of the construct. Consequently, higher scores on the constructs reflect greater progress with recovery.

The seven supplied elements in the recovery repertory grid included self comparisons or "possible selves" ("Myself as I am now," "Myself as I usually am," "Myself when mentally unwell," "Myself in two years" and "My ideal self") as well as comparisons with others ("An average person" and "A person when mentally unwell"), which were in part derived from previous studies conducted by Bell and McGorry (1992) and Harrigan (1999).

The seven supplied bi-polar constructs in the repertory grid reflect core recovery themes. These recovery themes were derived from the "Stages of Recovery Model" (Andresen, Oades, & Caputi, 2003; 2006) and include: Meaningless life – Meaningful life, Hopeless life – Hopeful life, Unhealthy – Healthy, Out of control of health – In control of health, Others make decisions – Makes own decisions, Directionless – Has direction, and Passive in treatment decisions – Active in treatment decisions.

Statistical Analysis

Construct Validity

Pearson correlations (one-tailed) between the construct profiles (e.g.

Meaningless life—Meaningful life) for the element "Myself as I am now" used on the repertory grid and the recovery measures (e.g., RAS) were conducted.

Identity Elements and Recovery

Analysis of the repertory grid data was based on the generation of distance measures between the various grid elements (elements profiles). That is, the distance between one element across a number of constructs and another element across the same constructs (e.g. the distance between "Myself as I am now" across all constructs and "My ideal self" across all constructs). City block distances were used to determine the degree of dissimilarity between specific elements on the basis of the given attributes or constructs. Pearson correlations (two-tailed) were conducted between the element distance measures and measures of hope, meaning, responsibility and recovery. Negative correlations between the element distance measures and the recovery measures indicate that as the distance between the two elements decreases there is an increase in the recovery measure scores.

TABLE 1—CORRELATIONS BETWEEN THE CONSTRUCTS BASED ON THE ELEMENT "MYSELF AS I AM NOW" ON THE REPERTORY GRID AND MEASURES OF RECOVERY

Constructs	Measures †					
	Hope Agency	Hope Pathway	Hope Total	RAS	SpREUK	PHMQ
Meaningful life	0.23	0.37**	0.34*	0.42**	0.31*	0.41**
Hopeful life	0.38**	0.45**	0.46**	0.49**	0.46**	0.35*
Healthy	0.31*	0.16	0.26	0.29*	0.31*	0.09
In control of health	0.35*	0.21	0.31*	0.32*	0.28*	0.16
Makes own decisions	0.23	0.32*	0.31*	0.32*	0.36*	0.23
Has direction	0.48**	0.47**	0.52**	0.55**	0.50**	0.49**
Active in treatment decisions	0.17	0.29*	0.26	0.34*	0.31*	0.33*

† $n = 40$. * $p < 0.05$, ** $p < 0.01$ (one-tailed).

Results

Participants

Based on the Self-Identified Stage of Recovery measure (Andresen, Caputi, & Oades, 2006) the 40 participants identified themselves in the following categories: moratorium 18%, awareness 13%, preparation 28%, rebuilding 28% and growth 13%. Therefore, the majority of participants viewed themselves as being in the middle to later stages of recovery. The mean age of participants was 40.95 years ($SD = 10.45$, range = 22-63), with 60% being male.

Construct Validity

Table 1 displays the correlations between the repertory grid construct ratings for the element “Myself as I am now” and the other recovery based measures.

The results indicate that 76% of the constructs correlated significantly with the other measures of recovery, 100% with the general recovery measure RAS. Particularly noteworthy are the grid constructs related to having “direction” and “hope” being significantly correlated with all other measures. The construct which correlated the least with the recovery measures was that of “Unhealthy – Healthy.” These findings suggest that the constructs used in the repertory grid did reflect the psychological recovery themes (Andresen, Oades, & Caputi, 2003).

Perceived Similarity Between the Average Element Ratings Across all Constructs

Descriptive statistics for the average element ratings across all constructs are provided in Table 2. The larger the mean element rating, the more the element is perceived to reflect constructs related to more advanced recovery processes. As evident in Table 2 the “ideal self” was perceived to reflect more advanced recovery processes,

TABLE 2—MEANS AND STANDARD DEVIATIONS FOR THE AVERAGE ELEMENT RATINGS ACROSS ALL CONSTRUCTS

Element	Meant	SD
My ideal self	4.14	1.11
Myself in two years	4.12	1.08
An average person	3.50	.94
Myself as I usually am	3.38	.88
Myself as I am now	3.35	.92
Myself when mentally unwell	2.23	.98
Person when mentally unwell	2.15	.90
† $n = 40$		

while “a person who is mentally unwell” reflected the recovery constructs least of all the elements.

Repeated measures t -tests were conducted on the average element ratings for the seven elements to examine potential differences between the different elements. This analysis found that there was no significant difference between a number of the elements, which suggests that these elements are perceived as being similar. The elements with no significant difference between them formed three distinct groups.

Group 1 consists of the elements “Myself as I usually am,” “An average person” and “Myself as I am now”

(“Myself as I usually am” and “An average person” ($t_{(39)} = .57, p = .57$); “Myself as I usually am” and “Myself as I am now” ($t_{(39)} = .25, p = .80$); “An average person” and “Myself as I am now” ($t_{(39)} = .77, p = .45$)). Group 2 consists of the elements “My ideal self” and “Myself in two years” ($t_{(39)} = .13, p = .90$). Group 3 consists of the elements “Myself when mentally unwell” and “A person when mentally unwell” ($t_{(39)} = 1.00, p = .32$).

Distance Measures Between “Myself as I Am Now” and All Other Elements

The descriptive data for the distance measures between the element “Myself as I am now” and all other ele-

TABLE 3—MEANS AND STANDARD DEVIATIONS FOR THE DISTANCE MEASURE BETWEEN THE ELEMENT “MYSELF AS I AM NOW” AND ALL OTHER ELEMENTS

Element	Meant	SD
Person when mentally unwell	10.00	5.73
Myself when mentally unwell	9.70	5.68
My ideal self	9.10	6.39
Myself in two years	8.73	5.72
An average person	7.90	6.00
Myself as I usually am	4.68	5.29
† $n = 40$		

TABLE 4—CORRELATIONS FOR THE DISTANCE MEASURE BETWEEN THE ELEMENT “MYSELF AS I AM NOW” AND ALL OTHER ELEMENTS AGAINST MEASURES OF RECOVERY

Elements	Measures †					
	Hope Agency	Hope Pathway	Hope Total	RAS	SpREUK	PHMQ
Myself as I usually am	- 0.05	- 0.35*	- 0.23	- 0.10	- 0.18	- 0.003
An average person	- 0.18	- 0.18	- 0.20	- 0.02	- 0.27	0.07
Person when mentally unwell	0.10	0.17	0.15	0.25	0.17	0.15
My ideal self	- 0.28	-0.35*	-0.35*	- 0.24	- 0.26	- 0.12
Myself in two years	- 0.15	- 0.24	- 0.22	- 0.12	- 0.20	0.05
Myself when mentally unwell	0.10	0.13	0.12	0.26	0.22	0.24

† $n = 40$. * $p < 0.05$ (two-tailed).

ments are provided in Table 3. The smaller the mean values, the more similar participants perceive themselves as they are now to that particular element. Participants perceive themselves now as most similar to their usual self (“myself as I usually am”) and least similar to a “person when mentally unwell.”

The result of the correlational analyses is presented in Table 4. The distance between “Myself as I am now” and “Myself as I usually am” was significantly negatively correlated with Pathway (i.e. goal-directed planning) ($r = -.35$, $p = .03$). This finding indicates that the more participants perceive themselves now as being more similar to their usual self, the more able they are to identify ways in which to achieve their goals.

The distance between “Myself as I am now” and “My ideal self” was significantly negatively correlated with Pathway ($r = -.35$, $p = .03$) and Hope ($r = -.35$, $p = .03$) and approaching a significant negative correlation with Agency (i.e. goal directed determination) ($r = -.28$, $p = .08$). This result suggests that the more participants perceive themselves now as being

increasingly similar to their ideal self, the greater their determination and the more they are able to identify additional ways in which to achieve their goals, thus being more hopeful.

Discussion

Overall, the recovery grid method shows promise as a valid measure of recovery constructs in terms of a person’s conception of his/her current self. Particularly noteworthy is the strength and consistency of the correlations between other measures of recovery processes and the repertory grid constructs of “Meaningful life,” “Hopeful life,” and “Has direction.” This may mean that “hope,” “meaning” and “having direction” are influenced by, or sensitive to a range of variables such as one’s capacity to problem solve and discern multiple ways to obtain goals (pathway thinking) and one’s readiness for active involvement in, or management of one’s own recovery. Alternatively, the more meaning, hope and sense of direction people have, the more likely they will be to problem solve/plan and be more actively involved in managing their own recovery.

The grid constructs that were unrelated to active involvement in recovery management and problem solving/planning were “control of health” and the quality of one’s own health. This implies that people believed that health and control of health was not impacted by efforts to self-manage illness and problem solve/plan one’s recovery steps. Interestingly, the more people felt in control of their health and that their health was good, the more they perceived themselves to be further along their recovery journeys, the more positively they perceived their illness, and the more self-determined they felt. These somewhat contradictory results suggest some independence between more subjective recovery experiences (e.g. illness acceptance) and more behavioral indicators of personal mastery (e.g. problem solving). Alternatively these results might indicate measurement issues with the “health” and “control of health” constructs. For example, some people may have been focusing on physical health alone when completing these scales while others may have been considering health more broadly (e.g., mental, psychological health, etc).

Similarly, the “agency” subscale scores of disposition hope produced some unexpected findings. That is, contrary to expectations there was no relationship found between “agency” and the “makes own decisions” and “active in treatment decisions” repertory grid constructs. Although conceptually these variables may be linked there seems to have been some discernment of decision making, particularly regarding treatment issues, from one’s confidence and determination regarding pursuing goals. It could be speculated that these results reflect the challenge of recovery principles (e.g. self-determination, setting own goals) within the context of people being traditionally disempowered in terms of treatment decision making. This is supported in the literature where treatment is compromised when health care providers and people have different goals in relation to treatment, and when goals are in agreement people have higher self-efficacy and this may lead to improvements in patient outcomes (e.g., Frantse & Kerns, 2007).

The recovery grid also offered the possibility to explore these constructs across the complexity of perceptions of other possible selves (e.g. ideal self), including projections of other people (e.g., person when mentally unwell) in terms of the degree to which the individual currently identifies with these various self experiences/images. It was found that the more the participants perceived themselves currently as more similar to their “ideal” and “usual” selves the more hopeful they were, in terms of problem solving and goal planning. Self-discrepancy theory states that when there is a discrepancy between a person’s actual and ideal self this signifies “a particular type of negative psychological situation” (Higgins, 1987, p. 322) which generates feelings of frustration and disappointment (i.e. psychological distress).

However, the current study found that there is also an association between self-discrepancy associated with improvements in recovery/wellness indicators (e.g., hopefulness). Therefore self-discrepancy has value in terms of exploring both illness and well-being dimensions of recovery.

Interestingly, no other distance measures between current self and the other elements correlated with the recovery measures. This is somewhat surprising considering previous research finding a correlation between increased identification with one’s ideal self and better treatment outcomes (Winter, 1992a). However, in line with the above argument about the “agency,” “pathway” and “active involvement” results, conceptualizing an “ideal self” has its own value but is not necessarily the same as taking behavioral steps to close the gap between one’s vision for oneself and one’s current self. These findings seem to reflect functions of the sample’s recovery stage (i.e. 56% being in the preparation and rebuilding stages), in that there appeared to be some disengagement from identifying with being unwell, some conceptualizing of the preferred identity or ideal self and goal planning, but still some distance to go before further identification with the ideal self.

The current study found that the ideal self was perceived as similar to the self in two years, indicating that the ideal self was considered in terms of a future self for this sample. These findings reflect the tension between viewing recovery as an outcome or as an ongoing process or lived experience (Andresen, Oades, & Caputi, 2003). The former would treat the ideal self as a future oriented goal that has an endpoint, while the latter might benefit from an emphasis on identifying opportunities in current life situations to act in ways consistent with valued life directions

(Hayes, Strosahl, & Wilson, 1999), or personal strivings, perhaps increasing hopefulness.

The majority of this study’s participants, who all experienced a psychotic disorder, perceived themselves to be in the middle to later stages of recovery (i.e. “preparation” and “rebuilding” stages as identified by the SISR ratings). Consequently, how well the results generalize to people, firstly with other mental illnesses, or in earlier stages (moratorium, awareness) and the final growth stage is unknown (Andresen et al., 2003; 2006). Having an increased number of participants within each stage would provide a better overall view of identity throughout the recovery process. An additional limitation involves the measures used which were recovery based and did not involve the traditional measures of symptomatology and functioning.

The repertory grid has been identified as a useful technique in therapeutic practice (Winter, 1992b) and shows promise in terms of exploring identity as a key variable in the recovery process. This specifically relates to a person’s conception of self/others and the degree to which they identify with these constructions.

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APPENDIX A—ONE ELEMENT FROM THE RECOVERY REPERTORY GRID.

The grid is concerned with the impressions you have of images of your self and ideals as well as impressions of some other people.

“Myself as I am now” refers to how you see yourself at this moment in time.

Circle a number between 1 and 5 on the scale below. For example, if your impression of yourself as you are now is that you have a very meaningless life, then circle “1” or “2” or, if your impression of yourself as you are now is that you have a very meaningful life, then circle “4” or “5.” By circling “3” you believe that your life is meaningful on some occasions and is meaningless on other occasions.

Definitely this end of the scale	←-----1-----2-----3-----4-----5-----→					Definitely this end of the scale
Myself as I am now						
Meaningless life	1	2	3	4	5	Meaningful life
Hopeless life	1	2	3	4	5	Hopeful life
Unhealthy	1	2	3	4	5	Healthy
Out of control of health	1	2	3	4	5	In control of health
Others make decisions	1	2	3	4	5	Makes own decisions
Directionless	1	2	3	4	5	Has direction
Passive in treatment decisions	1	2	3	4	5	Active in treatment decisions